I. The Rationale

At the beginning of the section on Physical Activity in Healthy People 2020 (https://www.healthypeople.gov/2020/topics-objectives/topic/physical-activity), it is stated that:

“The Goal is to improve health, fitness, and quality of life through daily physical activity. Released in 2008, the Physical Activity Guidelines for Americans (http://health.gov/PAGuidelines/) is the first-ever publication of national guidelines for physical activity. The Physical Activity objectives for Healthy People 2020 reflect the strong state of the science supporting the health benefits of regular physical activity among youth and adults, as identified in the PAG. Regular physical activity includes participation in moderate and vigorous physical activities and muscle-strengthening activities.

“More than 80 percent of adults do not meet the guidelines for both aerobic and muscle-strengthening activities. Similarly, more than 80 percent of adolescents do not do enough aerobic physical activity to meet the guidelines for youth. Working together to meet Healthy People 2020 targets via a multidisciplinary approach is critical to increasing the levels of physical activity and improving health in the United States.

“The Physical Activity objectives for 2020 highlight how physical activity levels are positively affected by: Structural environments, such as the availability of sidewalks, bike lanes, trails, and parks; Legislative policies that improve access to facilities that support physical activity; New to Healthy People 2020 are objectives related to policies targeting younger children through: Physical activity in childcare settings; Television viewing and computer usage; Recess and physical education in the Nation’s public and private elementary schools.

“Why Is Physical Activity Important? Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of: Early death, Coronary heart disease, Stroke; High blood pressure; Type 2 diabetes; Breast and colon cancer; Falls; Depression. Among children and adolescents, physical activity can: Improve bone health; Improve cardiorespiratory and muscular fitness;
Decrease levels of body fat; Reduce symptoms of depression; (to which I would add, establish a pattern of healthy living that can benefit them for their whole lives). For people who are inactive, even small increases in physical activity are associated with health benefits.

“Understanding Physical Activity. Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity. Factors positively associated with adult physical activity include: Postsecondary education; Higher income; Enjoyment of exercise; Expectation of benefits; Belief in ability to exercise (self-efficacy); History of activity in adulthood; Social support from peers, family, or spouse; Access to and satisfaction with facilities; Enjoyable scenery; Safe neighborhoods.

“Factors negatively associated with adult physical activity include: Advancing age; Low income; Lack of time; Low motivation; Rural residency; Perception of great effort needed for exercise; Overweight or obesity; Perception of poor health; Being disabled.

Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.


“Physical activity offers one of the greatest opportunities for people to extend years of active independent life and reduce functional limitations. . . . A substantial body of scientific evidence that indicates regular physical activity can bring dramatic health benefits to people of all ages and abilities, with these benefits extending over the lifespan. Physical activity offers one of the greatest opportunities to extend years of active independent life, reduce disability, and improve the quality of life . . . .”


The position taken by these reports was shaped by four important developments that have taken place over the past half-century (Paffenbarger, R.S., “An Introduction to the Journal of Physical Activity and Health, “Journal, 1, 1-3, 2004). First, the biomedical community identified and clearly described those aspects of physical fitness that are related to health. Second, the scientific knowledge base underlying the original hypothesis that regular physical activity benefits health became firmly established. Third, the epidemiology of physical activity (and inactivity) undertaken by the U.S. population and others has been studied and described in increasing detail over the years. Fourth, it has been recognized that moderate, as well as intense, physical activity carries with it health benefits.
Back in 1996, in terms that remain most apt to this day, Dr. Audrey F. Manley, then Acting Surgeon General, said (Preface to Physical Activity and Health: A Report of the Surgeon General (Atlanta, GA: USDHHS, CDCP, National Center for Chronic Disease Prevention and Health Promotion, 1996):

“We must get serious about improving the health of the nation by affirming our commitment to healthy physical activity on all levels: personal, family, community, organizational, and national. Because physical activity is so directly related to preventing disease and premature death and to maintaining a high quality of life, we must accord it the same level of attention that we give to other important health practices that affect the entire nation.”

A major challenge is how to use all of our knowledge and understanding to actually help patients/clients become regular exercisers at a level that is both comfortable for and useful to them. It is well-known that clinical advice of the appropriate type, provided in an appropriate way by physicians and other clinical health care professionals, can help patients/clients to unleash their own motivational process to become regular exercisers. This presentation contains some thoughts about how to go about doing this task effectively.

A full, broad-based approach to that challenge is contained in the American College of Sports Medicine's Exercise is Medicine® program. With my colleague Edward Phillips, Director of the Institute of Lifestyle Medicine at Harvard, I was privileged to write textbook for the program (see Resources, below).

In 2007 the original “Exercise is Medicine® Task Force” set forth the Vision of the enterprise as follows ((http://www.exerciseismedicine.org/about.htm):

“To make physical activity and exercise a standard part of a disease prevention and treatment medical paradigm in the United States.

“For physical activity to be considered by all healthcare providers as a vital sign in every patient visit, and that patients are effectively counseled and referred as to their physical activity and health needs, thus leading to overall improvement in the public's health and long-term reduction in healthcare cost.

“Exercise Is Medicine® will be a sustainable national initiative that:

1. Creates broad awareness that exercise is indeed medicine.
2. Makes ‘level of physical activity’ a standard vital sign question in each patient visit.
3. Helps physicians and other healthcare providers to become consistently effective in counseling and referring patients as to their physical activity needs.
4. Leads to policy changes in public and private sectors that support physical activity counseling and referrals in clinical settings.
5. Produces an expectation among the public and patients that their healthcare providers should and will ask about and prescribe exercise.
6. Appropriately encourages physicians and other healthcare providers to be physically active themselves.
“The Program Elements as originally laid out were:

Area 1. Make available tools, training, and referral mechanisms for physicians and other healthcare providers.

Area 2. Strengthen the science and evidence for the efficacy of exercise prescription in healthcare settings.

Area 3. Pursue policy interventions that support Exercise is Medicine®.

Area 4. Stage patient advocacy and marketing campaigns.

Area 5. Build coalitions and partnerships.

Area 6. Identify, develop, and disseminate "what works" models for patients as well as entire communities.

Area 7. Create a Web site with strategy, content, and functions that support all the program elements of Exercise Is Medicine®

The book is designed specifically to assist physicians and indeed all health care professionals who are interested in helping patients and clients to become regular exercisers in learning how they can most effectively do that. Our book covers the regular exercise waterfront, from helping you to organize your own mind-set for the process, to mobilizing patient/client motivation, which we see as the key element in the whole enterprise, through the nuts and bolts of what to do and how to do it, finishing up with how to have fun as a regular exerciser. We go in depth into both the lifestyle exercise approach to exercising regularly and the structured exercise approach.

II. Health Promotion and Disease Prevention/Treatment/Management Benefits of Regular Physical Activity (in more detail)

The evidence that demonstrates the health and wellness benefits of regular exercise was considered in great depth by the aforementioned Physical Activity Guidelines Advisory Committee that reported to the Office of Public Health and Sciences of the US Dept. of Health and Human services in 2008. Their report is contained in the Physical Activity Guidelines Advisory Committee Report, 2008, Washington, DC: US Dept. of Health and Human Services (http://health.gov/PAGuidelines/) and the summary conclusions are quoted just below. See also: https://www.nhlbi.nih.gov/health/health-topics/topics/phys/recommend

“A. General

Very strong scientific evidence based on a wide range of well-conducted studies shows that physically active people have higher levels of health-related fitness, a lower risk profile for developing a number of disabling medical conditions, and lower rates of various chronic diseases than do people who are inactive.
“B. Children and Youth

Strong evidence demonstrates that the physical fitness and health status of children and youth are substantially enhanced by frequent physical activity. Compared to inactive young people, physically active children and youth have higher levels of cardiorespiratory endurance and muscular strength, and well-documented health benefits include reduced body fatness, more favorable cardiovascular and metabolic disease risk profiles, enhanced bone health, and reduced symptoms of anxiety and depression.

“C. Adults and Older Adults

Strong evidence demonstrates that, compared to less active persons, more active men and women have lower rates of all-cause mortality, coronary heart disease, high blood pressure, stroke, type 2 diabetes, metabolic syndrome, colon cancer, breast cancer, and depression. Strong evidence also supports the conclusion that, compared to less active people, physically active adults and older adults exhibit a higher level of cardiorespiratory and muscular fitness, have a healthier body mass and composition, and a biomarker profile that is more favorable for preventing cardiovascular disease and type 2 diabetes and for enhancing bone health. Modest evidence indicates that physically active adults and older adults have better quality sleep and health-related quality of life.

“D. Older Adults

In addition to those benefits listed above, strong evidence indicates that being physically active is associated with higher levels of functional health, a lower risk of falling, and better cognitive function.

“E. Women During Pregnancy and the Postpartum Period

Strong evidence indicates that moderate-intensity physical activity during pregnancy by generally healthy women increases cardiorespiratory and metabolic fitness without increasing the risk of low birth weight, preterm delivery, or early pregnancy loss. Moderate intensity physical activity during the postpartum period does not appear to adversely affect milk volume or composition or infant growth. Physical activity alone does not produce weight loss in postpartum women except when combined with dietary changes.

“F. Persons with Disabilities

For many physical and cognitive disabilities, scientific evidence for various health and fitness outcomes is still limited due to the lack of research. Moderate to strong evidence indicates that increases in aerobic exercise improve cardiorespiratory fitness in individuals with lower limb loss, multiple sclerosis, stroke, spinal cord injury and mental illness. Limited data show similar results for people with cerebral palsy, muscular dystrophy, and Alzheimer’s disease. Moderate to strong evidence also
exists for improvements in walking speed and walking distance in patients with stroke, multiple sclerosis, and intellectual disabilities. Moderately strong evidence indicates that resistance exercise training improves muscular strength in persons with such conditions as stroke, multiple sclerosis, cerebral palsy, spinal cord injury, and intellectual disability. Although evidence of benefit is suggestive for such outcomes as flexibility, atherogenic lipids, bone mineral density, and quality of life, the data are still very limited.

“G. Persons Who Are Overweight or Obese

Strong evidence shows that physically active adults who are overweight or obese experience a variety of health benefits that are generally similar to those observed in people of optimal body weight (body mass index [BMI] = 18.5-24.9). These benefits include lower rates of all-cause mortality, coronary heart disease, hypertension, stroke, type 2 diabetes, colon cancer, and breast cancer. Some of these benefits appear to be independent of a loss in body weight, while in some cases weight loss in conjunction with an increase in physical activity results in even greater benefits. Because of the health benefits of physical activity that are independent of body weight classification, adults of sizes and shapes gain health and fitness benefits by being habitually physically active.”

III. The Primary Goal of this Exercise on Exercise, as Addressed to the Practitioner (from here on, the material is mine)

The primary goal of this exercise is to help the clinician develop and implement a plan for incorporating regular exercise promotion into his or her practice. The process of doing so is perhaps best approached by answering a series of questions that the practitioner might ask him or herself at the end of it.

* Is exercise promotion important in my practice, and why? For which patients/clients?

* For any endeavor in this area, what should the goals be, for my patients/clients, for myself, for the practice?

* If I think that there is some stuff to learn here, how much time do I want to invest in doing so, if any? And if not I, then who?

* Who should do the counseling? I? Members of my staff? Somebody new whom I might bring in part-time, like a physical therapist, a sports trainer, or a health educator?

* Whoever does it, how is this function going to be paid for? Do I charge patients/clients for this service? If so, how and how much?

* Do I want to try using patient groups for exercise promotion?

* What about making use of community resources?
* How much time am I willing to invest in developing an exercise promotion component in my practice?

* Is role-modeling important for patients/clients? If so, by whom? Do I want to invest my personal time in this?

* In terms of the specifics, how should I go about learning them, incorporating them into my own base of knowledge and skills?

* Considering key concepts: “Should” should not be used; patient/client “choices” should be central; “mobilizing motivation” is the first objective (see IV, below); time availability and/or lack thereof must be recognized; “the hard part of regular exercise is the regular, not the exercise”; Rome wasn’t built in a day and neither is permanent lifestyle change.

IV. How do We Get There? How do We help out Patients and Clients Move on to a Healthier Life-Style?

A. Let’s begin with some basics

Over the many years that I have worked in this field, I have put together what I call “The ‘Basic Ten’ of Health Promoting Behavior Change.” They are:

1. If all we needed to live a healthy life were information about what to do and why to do it, in the United States at least, and surely in many other nations around the world, we would all live in a world of very healthy people. We are surrounded by the stuff.

2. Motivation, rather, not simply information on the “why” and the “what,” is the central element for any person who wants to engage in any health-promoting behavior on a regular basis; mobilizing it is the key.

3. What is “motivation?” Most simply, it is not a thing. It is not something that one can buy in a package, that someone can give to someone else. It is rather an individual mental process that links a thought or a feeling with an action.

4. Helping the patient/client to “mobilize their motivation” should be the first objective of any regular exercise promotion program, indeed of any health promotion program in general.

5. Goal-setting, deciding “what is it that I want to do, and why do I want to do it” is the central element in mobilizing motivation.

6. If they are to work for any given person, the goals that are set must be reasonable and rational ones, for that person.
7. The concept of “should,” implying guilt feelings at one level of another, Should not be used with patients/clients attempting to turn their lifestyles towards health.

8. When choices are to be made, those of the patient/client should be central, except when the practitioner determines that a particular patient’s choice could actually be harmful for their health.

9. Time availability and/or lack thereof must be recognized as an issue, for any patient/client.

10. Neither Rome nor Nassau was built in a day and neither is permanent lifestyle change.

It cannot be emphasized enough that the most important element of this list is the one about “mobilizing motivation.” Exercising regularly takes commitment; it takes setting a schedule and sticking to it; it takes, from time-to-time, dealing with inconvenience, with pain, with other priorities.

To further help us focus here, to the “Basic Ten” above, I add five of my Favorite Sayings, which can help both the care-giver and the patient/client focus on the matter at hand.

1. “Gradual change lead to permanent changes.”

2. “Explore your limits while recognizing your limitations.”

3. “The hard part of regular exercise is the regular, not the exercise.”

4. “In training, the keys are consistency and regularity.”

5. “In training, time is the common denominator. In the distance sports specifically, minutes work for some folks; miles work for others.”

V. Then with some overlap, there are my “Basic Eight of Regular Exercise:”

Many years ago, towards the beginning of my 30-plus years in multi-sport racing and as a writer on the subject I put together what I call the “Basic Eight of Regular Exercise.” Do note that there is some repetition with the “Basic Ten of Health-Promoting Behavior Change.

1. The hard part of regular exercise is the regular, not the exercise. Believe me, I know, and live this principle very well. There are surely those mornings (and I work out in the morning) when man, I just don’t feel like getting out there. But I do know just how important getting out there is.
While I do take a very occasional day off (like I did just this morning), most of the time I do get out there, and then guess what? 10 minutes into the workout I’m very glad that I did.

2. The best exercise routine for you is the exercise routine that is best for you. There are numerous choices. One size does not fit all. This applies to multi-sport racing as well as to training for it. There are so many articles that say “do it this way, and you are sure to . . .” Well, maybe, and, as I have said so many times, it all depends what your goals are, and they may very well not be the goals of that particular writer.

3. There are many reasons for exercising regularly, other than for race training. Most folks who do it will tell you that the most important ones are that regular exercise makes you feel better and feel better about yourself, as well as making you look better and look better to yourself. Those are certainly my principal reasons, even though as a preventive medicine doc I know that there are plenty of health-promoting reasons to do it too.

4. Indeed, regular exercise can: reduce your risk of developing heart disease, overweight, high blood pressure, stroke, certain kinds of cancer, diabetes, osteoporosis (bone softening associated with ageing), and even depression and chronic anxiety. There are no guarantees here, but the risk goes down for getting all of these major illnesses. It’s also very helpful in managing many of the same conditions.

5. Gradual change leads to permanent changes: don’t try to do too much too soon, either in your training or your racing, both over the course of a season and over the course of several seasons.

6. Explore your limits; recognize your limitations. I myself learned this lesson very early on, in my first triathlon (at age 46) as it happens. I was pretty sure that I was going to be pretty slow, and I focused on, as I like to say, finishing happily and healthily (and relatively slowly too!) And I did!

7. Effective mobilization of your motivation is the key to long-term success, first as a regular exerciser and then as a multi-sport racer.

8. We can never be perfect; we can always get better. If you can embed this one in your mind, you can a long and successful (for you) career in tri/duathlon, regardless of your speed or athletic ability.
VI. **The Program: First Thoughts**

A. The focus of this session is on the otherwise healthy patient:

1. The sedentary person who wants to become a regular exerciser.
2. The sedentary person who needs to become a regular exerciser for risk factor modification.
3. The former or present regular exerciser who is looking for special consultation, because of injury or burnout, or is in need of re-focusing/reinforcement.

B. Why use the word “recommendation” rather than “prescription?”

1. The permanent time-intrusiveness of regular exercise and the need to recognize that reality. Because of its special nature among the set of health-promotive/disease-preventive interventions, regular exercise cannot be prescribed like a drug.
2. The need to spend some time with the patient just talking, discussing pros and cons, defining both facilitating and limiting factors, especially recognizing barriers, to help patients/clients equip themselves with the tools to use the facilitating factors and breach the barriers.

C. For almost everyone, the hard part of regular exercise is the “regular,” not the “exercise.” This therefore ought to be a principal focus in counseling patients, both those starting out, and also those who are staying with it.

VII. **The Ordinary Mortals ® Pathway to Mobilizing Motivation** (see Appendix I for more detail on this subject)

A. The first step is assessment, of self, of the situation or other person being addressed, or both.

B. Next is to define success, in context, realistically, so that it is at least within the realm of possibility.

C. The third step is goal-setting, the central element of the Wellness pathway. All the rest is commentary.

D. The fourth step is establishing priorities.

E. The fifth step is taking control.

F. The keys to taking control: how patients/clients can overcome their internal barriers to becoming a regular exerciser.

1. Understanding that motivation is not a thing, but a process that links a thought to a feeling with an action.
2. Following the first four steps of the Wellness Motivational Process from the beginning.

3. Examining what one already does well; health-promoting behavioral changes already made.

4. Recognizing that gradual change leads to permanent changes.

5. Dealing with the fear both of failure and of success.

6. The readiness to explore one’s limits while recognizing one’s limitations.

7. Appreciating the process of psychological immediate gratification.

VIII. **Choosing the activities/sport (s).** (See Appendix I for suggested readings describing some of the options.)

A. The choice of sports is extensive.

   1. Skill/non-skill
   2. Outdoor, aerobic
   3. Indoor, aerobic
   4. Non-aerobic
   5. Weight-training
   6. Team

B. Very important: different strokes for different folks; one size does not fit all. Thus, choosing what works, what the person likes: “The best exercise for you is the exercise that’s best for you.”

C. Aerobic and non-aerobic exercise: what each does and does not do for the exerciser.

D. The “Lifestyle” approach (building physical activity into the regular patterns of daily living) vs. the “Scheduled Leisure Time Workout” approach. The advantages and disadvantages of each.

IX. **Making exercise fun**

A. Letting it be fun: the importance of positive anticipation

B. Setting appropriate goals.

C. Not doing too much, too soon.

D. Minutes, not miles.

E. Private time, thinking time.

F. Routes and companions.

G. Listening to music or the news on the radio, to books, courses on tape; safety considerations.

H. Setting non-exercise related goals for the workout, like getting an errand or two done in the course of.

I. Giving oneself a reward periodically.

J. Seasonal variation.
K.  Enjoying the rhythm that is part of many aerobic sports.
L.  Enjoying the outdoors.
M.  Exercising while traveling.
N.  Racing.
O.  Taking time off when needed, but in any case at least 1-2 times/year.

X.  **The Generic Training Program: Primary Elements**

A.  The **first** focus **must** be on the regular, **not** the exercise.
B.  Time: 4-5 days per week for a total of 2.5 hrs. or more (see the new DHHS Physical Activity Guidelines).
C.  Walking as what I call the FAST: Foundation Aerobic SporT.
D.  Minutes not miles.
E.  Heart rate and/or "perceived exertion," not speed, as measures of intensity.
F.  The importance of consistency and regularity.
G.  Workout schedules (see Appendix II).

XI.  **Technique and Equipment**

A.  On technique, it is hardly necessary to be an expert in all sports, or even one. Familiarity with one or more good books and magazines in the most popular sports will be very helpful (see Appendix I).

B.  On equipment, the shoe is the most important piece of equipment for many of the aerobic sports. A good shoe is essential to safe, enjoyable participation in them. Understanding shoes and what good fit is, is very helpful for patients/clients.

   Thus: the shoe should be shaped like one's foot; it should touch the foot in as many places as possible, except over the toes; it should be flexible under the ball of the foot; it should have a firm heel counter, to keep the heel down in the shoe.

   While the non-specific "cross-trainer" can be fine for someone starting out and not knowing for sure what sport they will engage in, once one or more sports are selected, sport-specific shoes are recommended. The cross trainer will work, of course, for the gym, and, for most people, if well-fitted, for exercise walking. However, in most cases, the shoe selected should be specific to the sport selected.
C. Appreciate and recommend the “pro shop” for specialty items like running shoes, bikes and bike-equipment, and home exercise and weight-lifting machines. Purchasing any kind of sports equipment in department stores, generic discount houses, or even sports "super-stores," in which the quality of the help can be very uneven, is not recommended.

X. The importance of role-modeling.
   A. Although not essential, setting an example is very helpful.
   B. Being able to talk from experience: knowing both the benefits and the difficulties of being a regular exerciser.
   C. Being able to share sport-specific experience and experiences.

XI. The Use of Community Resources
   A. What they are: health clubs, gyms, pools, tracks, bike routes, walking/running trails, courts, sports clubs, pro shops.
   B. Spend some time learning about/evaluating them, saving much time for yourself in your practice while providing substantive assistance for your patients/clients.
   C. Consider setting up formal referral relationships with one or more community resources, as appropriate.

XII. The Essentials of Exercise Counseling
   A. The exercise counseling process as a partnership, not paternalism. The importance of interactive communication. Empowering the patient. Raising questions, not necessarily giving answers.
   B. Using the Wellness Motivational Process for Healthy Living in an active mode with patients/clients.
   C. The centrality of internal motivation.
   D. The importance to the patient of commitment and scheduling.
   E. The three M's: mentioning, modeling, motivating.
F. What to emphasize, of the possible outcomes.

1. Learning to, and being able to, take control.
2. Self-realization; discovering previously unknown aspects of oneself.
3. Feeling good now.
4. Weight and/or fat loss/physical appearance improvement.
5. Health benefits.

XIII. The Problem for the Clinician: How to reduce all of this material to a package that can be successfully used in clinical practice; some options.

A. First decide if doing that is important to you and for your patients/clients. It's the same goal-setting process that the successful regular exerciser undertakes as the first step. Use the question list on p. 3 above.

B. Offering individual counseling for a fee.

C. Setting up evening groups.

D. Using written materials.

E. Using community resources.

XIV. Primary Resources

General:


The Ordinary Mortals®* Pathway to Mobilizing Motivation

And so now we move on to the central element, that is how to help patients and clients mobilize their motivation for health-promoting behavior change. In a bit more detail, just what is motivation? The longer definition: Motivation is not a thing. It is a mental process that links an emotion, feeling, desire, idea, or intellectual understanding, or a recognized psychological, physiological, or health need, to the taking of one or more actions. The shorter definition: “Motivation is a mental process that links a thought or a feeling to an action.”

To help us understand how this process occurs, we begin with a widely used approach, previously developed for understanding how behavior change occurs, mentally. That would be the “Prochaska-DiClemente Model,” also known as the “Stages of Change/Transtheoretical Model.” It was originally designed by Profs. Prochaska and DiClemente (Prochaska, J.O., Norcross, J., and DiClemente, C. Changing for Good. New York: William Morrow, 1994.). It has Six Stages (EXPAND). They are designated as: 1. Pre-contemplation, 2. Contemplation, 3. Planning, 4. Action, 5. Relapse, and 6. Permanent Maintenance.

I have developed my own model for understanding the process of behavior change that goes beyond this Transtheoretical Model. I call it “The Six Phases of Behavior Change.” It moves forward from the Transtheoretical Model by recognizing that the key element in proceeding along the pathway towards Permanent Maintenance is crossing the bridge from planning to action. In my view, that requires the specific step of mobilizing motivation. And so, the Phases are:

1. Not on the radar screen.
2. Thinking about it.
3. Going to get going.
5. Getting going!
6. Making it part of one’s life.

From this understanding of behavior change, I developed the Ordinary Mortals® Pathway to Mobilizing Motivation. It itself has Five Steps:

1. Self-assessment, is asking yourself questions like: where am I now? How did I get here? What do I like about myself? What do I not like? What would I like to change? What is going on in my life that would facilitate behavior change? Inhibit it?

Please note that “Ordinary Mortals” is a registered trademark in the United States.
2. Defining success, has to be done in the context of you as a person, what your measure of your innate skills and capabilities is. To work for you, "success" as you define it has to be something that is reasonable, realistic, and conceivably achievable, for you, given who you are as a person and what else is going on your life (see also 4, below). In defining success for yourself, you have to make sure that you are not setting yourself up for failure. Defining success productively also includes giving yourself permission to fail, assuming that you really did try.

3. Goal-setting, the central element in the Pathway, both by location and importance, is accomplished by answering questions like: to where do I want to get? Why do I want to get there? For whom would I be making the change; others, or myself? What do I expect to get out of the change, should I achieve it? What do I think I can reasonably expect to do? What are the "give-ups," and can I, do I want to, commit to them? Arriving at satisfactory answers to these questions for yourself is absolutely key. For doing so, answering the questions "what do I really want to do and why do I want to do it," provides the focus and the concentration you must have in order to have the best chance of success in your chosen endeavour.

4. Establishing Priorities, among your specific goals and between your new goals and the rest of your life is central to making the whole process work for you. If you have set more than one goal, what is their ranking? Which do you consider to be the most important to achieve? Which the least? In addition, what about priorities between your new goal(s) and other important things that are going on in your life, like family, friends, other leisure time activities, and your job? (See also 2, above.) If juggling needs to be done, it will be very helpful to do some thinking about that and yes, set your priorities.

5. Taking Control, means putting yourself in charge of the whole process, adopting an "I can do this" attitude and perspective, given that the first four steps have been followed. It means not depending upon anyone else, but also not taking anyone else’s direction (advice on both process and content is fine, direction in the sense of “you must do this” is not), of accepting responsibility for both success and failure.

Taking Control itself has "Seven Keys"

Since for most people, making change for themselves, not anyone else, is central to achieving a successful outcome, taking personal control of the whole process is essential. Taking Control itself has seven keys (some of which by now should be familiar to the reader). (EACH WILL BE EXPANDED UPON)

1. Understanding for sure that motivation is not a thing, but a process that links a thought or a feeling with an action.

2. Following the first four steps of the Ordinary Mortals® Pathway to Mobilizing Your Motivation, from the beginning.

3. Making sure to examine what you already do well: health-promoting behaviors that are already part of your life.
4. Recognizing that gradual change leads to permanent changes.

5. Dealing with both the fear of failure and of success.

6. Being ready to explore your limits while recognizing your limitations.

7. Appreciating the process of psychological immediate gratification.
A listing of suggested readings on regular exercise for you and your patients

1. **Publications from the ISC Division of Wellness**


   Ibid., *Concepts of Heart Rate Monitor*, ISC Division of Wellness, 2007

   Ibid., *Concepts of Dehydration*, ISC Division of Wellness, 2007

   Ibid., *Concepts of Nutrition*, ISC Division of Wellness, 2007

   Ibid., *Lactate and Exercise*, ISC Division of Wellness, ISC 2005

   Matthew Werd and Leslie Knight, *Foot Care, Prevention and Treatment*, ISC Division of Wellness, 2004


   These books may all be ordered directly from the:
   **ISC Division of Wellness, PO Box 8798, Lakeland, FL 33806, tel. 1-800-477-8934**

2. **On Fitness in General**


3. **Running**


4. **Bicycling**


5. **Swimming and Water Exercise**


6. **Walking**


7. **Aerobics**

**General:**


8. **Weight Training**

**General:**


**For women:**


**For older folks:**


9. **Triathloning/Duathloning**


And see my (most) monthly blog for USA-Triathlon, at: [http://www.usatriathlon.org/search/site.aspx?q=Steve+Jonas&submit=Go%21](http://www.usatriathlon.org/search/site.aspx?q=Steve+Jonas&submit=Go%21)
10. **Stretching**

Appendix II

Table I

The Generic Exercise Plan

(begins with PaceWalking(tm), but the numbers apply regardless of sport)

Introductory Program

(Times in Minutes)

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Table II

The PaceWalking(tm) Plan: Phase II

Developmental Program

(Times in Minutes)

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Table IV

The PaceWalking™ Plan: Phase III B

Maintenance Plus: Three Hours Per Week

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